Diagnosis Related Groups – Part 2: Policy Added to Medi-Cal Provider Manual
The Medi-Cal provider manual has been updated with new diagnosis-related groups (DRG) policy. Effective for admissions on or after July 1, 2013, reimbursement for private inpatient general acute care hospitals is based on DRG payment methodology, except for rehabilitation services and administrative days.

DRG Terminology
The specific DRG algorithm chosen by the Department of Health Care Services (DHCS) is all patient refined diagnosis-related groups (APR-DRG). APR-DRGs are suitable for the Medi-Cal population because they account for recipients of different ages with a wide variety of clinical needs. For purposes of the provider manual, APR-DRG will be referred to as the DRG reimbursement method or DRG model. Hospitals reimbursed according to DRG guidelines will be referred to as DRG-reimbursed hospitals.

Note: Providers should not confuse references to the DRG method mentioned in the Medi-Cal provider manual with the DRG method applied to Medicare claims. The DRG algorithms applied to Medi-Cal claims differ from the algorithms applied to Medicare claims because Medicare serves mostly seniors.

New Manual Sections
New manual section *Diagnosis-Related Groups (DRG): Inpatient Services* is the main location for new DRG policy. The section includes the following:

- An overview of the DRG methodology
- Cross references to other provider manual sections updated with new DRG policy
- Treatment authorization charts that identify whether an inpatient service requires an approved TAR, and specifies which TAR form should be submitted
- Claim completion information, including instructions for a new claim requirement that a present on admission (POA) indicator is included, as appropriate, for the primary and all secondary diagnosis codes on the claim

Also new is the *Inpatient Rehabilitation Services* section. This section explains how to bill for acute inpatient intensive rehabilitation (AIIR) services, including physical rehabilitation in general acute care hospitals, physical rehabilitation in specialty rehabilitation facilities, and drug and alcohol rehabilitation in drug/alcohol facilities.

Two previous OB manual sections have been updated to incorporate DRG instructions. DRG has been added to the titles. The sections are the *Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals* and *Obstetrics: UB-04 Billing Examples for Inpatient Services – DRG Payment Method*.

Retained Manual Sections
Because claims can be submitted for up to a year from the date of service, several manual sections are being retained in the provider manual, though section content may be inaccurate for submitting claims for dates of admission after June 30, 2013. Information in the retained sections may refer to contract provisions, Health Facility Planning Areas (HFPAs) or other billing considerations that are being discontinued with the advent of DRG.

Boxed text has been added to the first page of these retained sections. The text cautions providers that "some instructions in this section are no longer supported." The retained sections are as follows:

Contracted and Non-Contracted Inpatient Services
Contracted Inpatient Services for Allied Health
Contracted Inpatient Services for Medical Services
Obstetrics: Revenue Codes and Billing Policy
Obstetrics: UB-04 Billing Examples for Inpatient Services

Removed/Replaced Manual Section
With the advent of DRG, the provider manual section containing the "selective hospital contracting list" is outdated. Therefore the *Contracted Inpatient Services: Selective Hospitals Directory* section is removed from the provider manual. It is replaced with the *Hospital Directory* section, which contains the DHCS public hospital list pertaining to certified public expenditure (CPE) reimbursement. Providers who maintain a hard copy manual should remove *Contracted Inpatient Services: Selective Hospitals Directory* from their manual.

DRG Policy Highlights
DRG policy highlights include the following:

- Extracorporeal Membrane Oxygenation (ECMO) inpatient services are billed with revenue code 174 (nursery newborn, Level IV) in conjunction with ICD-9-CM diagnosis code 39.65 (ECMO). ECMO services must be submitted on the claim with all revenue/sick baby codes applicable to the entire stay. The claim is submitted for services rendered to the baby only. Services to the mother are billed separately. ECMO services are paid according to the DRG reimbursement methodology. Refer to the *Medicine* section for this updated policy.
- Admit TAR/Daily TAR: An admit *Treatment Authorization Request* (TAR) is a TAR that is submitted to request authorization for the entire hospital stay. It differs from a daily TAR that identifies the specific number of hospital days for which authorization is requested. Refer to the new *Diagnosis-Related Groups (DRG): Inpatient Services* section for this clarified policy.
- Service Authorization Request (SAR) DRG policy updates are similar to TAR policy updates noted in the preceding bulleted item. Refer to the *California Children's Services (CCS) Program Service Authorization Request (SAR)* and *Genetically Handicapped Persons Program (GHPP)* sections for revisions.
- Administrative day level 2 services require a daily TAR. Refer to the new *Diagnosis-Related Groups (DRG): Inpatient Services* section for this policy.
- DRG is a system that uses information on the claim (including revenue, diagnosis and procedure codes, patient's age, discharge status and complications) to classify the hospital stay into an APR-DRG group. A percentage is assigned to the group. Basically, final payment for the hospital stay is calculated by multiplying the percentage associated with the group by the hospital's assigned base price.
- An APR-DRG grouper code will be reported on the *Remittance Advice Details* for paid claims only.
- No TAR is required for obstetric admissions associated with a delivery in cases where both the mother and newborn remain healthy. Refer to the *Obstetrics: Revenue Codes and Billing Policy for DRG-Reimbursed Hospitals* section for this clarified policy. (Please open the new DRG-related section, not the older section with the boxed text on page one that cautions providers that "some instructions in this section are no longer supported.")

Articles containing important DRG information previously ran in the *Medi-Cal Update* bulletins. Please see the October and November 2012 and January through April 2013 bulletins. The bulletins are available on the Medi-Cal website (**www.medi-cal.ca.gov**) and the Diagnosis Related Group Hospital Inpatient Payment Methodology Web page on the DHCS website.

Bone Marrow and Blood Factors: Outpatient Claim
Claims for acute inpatient services generally bill for all services rendered to the inpatient recipient. Bone marrow and contract blood factors are exceptions. Therefore, the following bone marrow and blood factors codes must be separately billed on an outpatient claim.

> Bone marrow code 38204 (management of recipient hematopoietic progenitor cell donor search and cell acquisition) and (unrelated bone marrow donor).
>
> Blood factor codes J7180, J7183, J7185 – J7187, J7189, J7190, J7192 – J7195, J7197 and J7198.

MIRL and PIRL
Due to the implementation of DRG reimbursement effective July 1, 2013, for private hospitals, the peer grouping inpatient reimbursement limitation (PIRL) and the maximum inpatient reimbursement limitation

(MIRL) for non-Selective Provider Contracting Program private hospitals shall no longer apply to inpatient services rendered after June 30, 2013. However, inpatient service admissions on or before June 30, 2013, that result in a discharge after June 30, 2013, shall be included in the private hospital's fiscal period ending 2013, or 2014 if applicable, for PIRL and MIRL determinations. (*California Code of Regulations*, Title 22, Sections 51545 to 51557).